Population Health - Phase 2 Report: NQF Public and Member Comments and Responses

No.	Commentor	Council/Public	Topic	Comment	Response
1	Submitted by Dr. Deborah Fritz, PhD, MPH	Council	General Draft	GSK recommends that consideration of leadership for health improvement include more that the two "mostly separate systems – clinical care and government health system" described on page 2 of the environmental scan paper commissioned for this project. Stakeholders involved in health improvement should be expanded to include other significant contributors such as life sciences organizations and patient advocacy groups. These organizations have a primary goal of improving the health of individuals and have a large impact on both individual and population health. These groups are important stakeholders as NQF moves forward. GSK also recommends consideration of patient and population health outcome measures that link to the public health activities described in the environmental scan (p. 8). Relevant measures include improvements in functional status and other patient reported outcomes such as the ability to carry out activities of daily living.	**NQF response:** Thank you for your feedback. NQF commissioned the Los Angeles County Department of Public Health and the Public Health Institute to develop the white paper on population health. The paper was posted to the NQF website for Member and public comment in March 2012. NQF staff will forward your comments and recommendations to the authors, who also note in the paper that "...the primary emphasis on the clinical care system and government public health system in this report should not be interpreted as meaning that other stakeholder organizations that contribute to overall health improvement are being disregarded or are not important. Indeed, many of the health improvement activities led by the government public health system rely on partnerships and collaborations with other government agencies, community-based organizations, academic institutions, and businesses."
2	Submitted by Dr. Thomas James, III, MD	Council	General Draft	Humana is pleased to have the opportunity to provide comment. We believe that population health goes well beyond the measurement of individual clinical standards but must encompass the emotional, security, safety, behavioral as well as the physical aspects of health. To get to this level will require joining of social sciences, behavioral health specialists, epidemiologists, and those engaged in improving the overall health of populations. The latter group does include health plans, departments of health, employers and consumer groups. All have a stake and all have elements of accountability that are part of the final population outcomes. We applaud the current proposed measure set but suggest that measures, such as fall prevention in the elderly, encompass that required community effort to reduce the morbidity and mortality associated with falls. The same applies to measures of rates of injury, successful or attempted suicide, or other significant impacts. As health plans we believe we can offer out reach, benefit incentives, and information to help affect population health We would appreciate joining in on enlarging the discussion.	**NQF response:** Thank you for your comments. We look forward to your continued involvement with future population health performance measurement initiatives. **Steering Committee response:** We appreciate your thoughtful comments and recommendations for potential partners and future measure development. We will incorporate your general suggestions in the draft technical report.
3	Submitted by Mr. John D. Shaw	Council	General Draft	(General Comments – Background - 1 of 2) Schools are "Places where Children Learn" - and where they spend 1/4 - 1/3 of their life. The Commissioned paper mentions briefly:"These synergistic efforts will truly empower individuals and families to make healthy choices wherever they live, work, learn, worship, and play." However, there is little specific recognition of schools. One of the hats I wear is Board President of Health Schools Network (HSN). HSN also convened and coordinates the Coalition for Healthier Schools (CHS), a public health focused coalition of national, state, and local Community representatives. CHS encompasses 37 sponsoring agencies, 147 U.S. groups, 17 International groups, and 1,084 concerned individuals as of November 2011. HSN and CHS focus on improving children's environmental health in these "Places They Learn." Schools are part of the "built environment" and as such directly impact children's health. Mechanisms which impact pediatric health outcomes found in the literature include: 1. Site selection (Proximity to industrial plants, dumps, highways, soil contaminants, etc.); 2. Building age and condition (Presence of moisture that supports growth of mold; insect and rodent infestations; dust in heating ducts; asbestos, mercury, and PCB exposures; toxic building materials and chemicals, etc.); 3. Indoor Environmental Quality (air quality, lighting, noise, etc.); 4. Outdoor Environmental Quality (Diesel school bus fumes, pollen, etc.) Schools also represent a gaping hole in the Public Health system – no one is in charge or accountable for children's health in schools. Schools are under local School Board jurisdiction, Federal and State Education has limited say, and lacks health program focus. Health officials at Federal, State, and Local levels have the knowledge, but no jurisdiction. This is barrier places all children at risk, particularly Elementary and L.D. students. Impact on pediatric health outcomes found in the literature and our work include: A. Young children are not capable of self management and school staff may be unaware which children are at risk (Class changes every year, HIPAA and FRPA privacy regulations, etc.); B. Classroom and Gym teachers may be aware of who is at risk, but may not have the knowledge of what to do about it (Allowing inhaler use before going outside and running in dusty conditions, recognizing symptoms of respiratory distress to send children to the school nurse, lack of school nurse in building due to sharing across buildings, etc.); C. Close proximity leading to spread of colds/flu that exacerbate Asthma; D. Lack of Coordination with PCP and other health providers (Absence of Asthma Action Plans	**NQF response:** Thank you for your comments. We look forward to potentially working with you on future population health performance measurement initiatives. **Steering Committee response:** We appreciate your thoughtful comments and recommendations for potential partners. Specifically, we will add your recommendation to partner with schools and others working to improve health and wellbeing in built environments in the draft technical report.

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4	Submitted by Mr. John D. Shaw	Council	General Draft	Continuation of Next Wave/HSN/CHS comments (Recommendations - part 2 of 2) Our general recommendation is that: Schools should be elevated as one of the focal points for Population Health initiatives (not just one word in a background paper). They are the places of learning where some of our most vulnerable population spend much of their time. Major Gap: Since no one is in charge of children's health in schools, there is also no good data source to link population health, healthcare encounters, and educational data to inform evidence-based targeting. Specific comments to NQF from our groups include: Include "school attended" as an element in all school-age child's health records, linkable to (or in) their encounter data. Some local studies found this to be a major focal point for identifying "hotspots". This lead to local action efforts to determine which areas are local drivers and address them, improving community health outcomes. Note: Like the Place of Origin and Year of Arrival measures not endorsed, this is not a measure in and of itself, but if collected can be utilized as a stratification variable for many pediatric measures (and some occupational health-related measures for adults who work in schools). HSN and CHS are currently in the process of searching for metrics for surveillance of both health and education outcomes and environmental and social determinants. CHS has a currently active national Research, Metrics, and Surveillance Workgroup that like NQF is seeking to "Identify other population-level measures in use and potential partners." We are also seeking to link these measures to health outcome and academic achievement metrics which initial studies have shown to be inter-related. We welcome the opportunity to work jointly with NQF to define, refine, and validate metrics in this area.Please contact me to pursue this further.	**NQF response:** Thank you for your comments. We look forward to potentially working with you on future population health performance measurement initiatives. **Steering Committee response:** We appreciate your thoughtful comments and recommendations for potential partners. Specifically, we will add your recommendation to partner with schools and others working to improve health and wellbeing in built environments in the draft technical report.
5	Submitted by Ms. Carmella Bocchino, MBA, RN	Council	General Draft	This set of population health measures is appropriate for provider-level measurement; however, measures should also be appropriate for health plan use and for providers who are responsible for managing populations under the new payment and delivery models. The measures are siloed and focus on specific points-of-care. There needs to be sharing of data across the public health and medical systems to enable improved measurement of population health. We encourage measure developers to continue to harmonize measures at all levels of analysis.	**Developer response:** Thank you for your feedback. NCQA agrees harmonization of measures where appropriate is important.
6	Submitted by Ms. Melanie Shahriary, RN, BSN	Council	General Draft	These comments are being submitted on behalf of the individual ACC members who reviewed this report and do not necessarily represent the opinion of the ACC or its members. The draft provides interesting insight in to factors that determine selection of metrics for population health. The measures chosen should perform well. With regards to other variables that could be considered for future drafts, how about counseling for physical activity and nutrition in younger and middle-aged adults (18-65 years)? Or other patient-reported behavioral measures like intake of fruits and vegetables, self-reported physical activity, adherence to medication prescription for CV risk factors, diabetes etc? Also, although measures that deal with physical environment (like air and water safety, safety at home) may not be modifiable at an individual or population level, evaluating their status may provide helpful information on population health as well. NQF should be advocating for measures at "the system level," especially in the area of population health—and should be specific about not using them at the physician level.	**Developer response:** NCQA agrees and will investigate these topics for future measure development.

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7	Submitted by Mr. Jordan Cooper	Council	General Draft	There needs to be more active alignment and harmonization among smoking, BMI, and physical activity measures. There are a plethora of competing or slightly similar measures that seem to focus on a narrowly defined setting or level of analysis. It would behoove the measurement enterprise if the endorsement process encouraged measures to apply across settings, including multiple levels of analysis so as to preempt a need for multiple measures in the same topical area that differ primarily in their setting or level of analysis.	**Developer response (NCQA):** Thank you for your feedback. NCQA agrees harmonization of measures where appropriate is important.
8	Submitted by Ms. Jennifer Eames Huff, MPH	Council	General Draft	There needs to be more active alignment and harmonization among smoking, BMI, and physical activity measures. There are a plethora of competing or slightly similar measures.	**Developer response (NCQA):** Thank you for your feedback. NCQA agrees harmonization of measures where appropriate is important.
9	Submitted by Lauren M. McKown, America's Health Insurance Plans	Public	2020: Adult Current Smoking Prevalence	Given that this measure is based on patient reported data, we are concerned with the validity and accuracy of patient responses across different populations. It is unclear whether testing data reveal any systematic biases in responses for different populations and if responses have been validated for accuracy as part of measure testing. We also agree with the Committee's recommendation to harmonize this measure with NCQA's measure #0027 Medical assistance with smoking and tobacco use cessation.	**Developer response:** Thank you so much for your comment. First off, I want to clarify that these are not patients. Rather, these are general members of the population. In general, self-reported smoking status is a valid indicator of population level smoking prevalence and most national surveys in the United States that assess health behavior rely on self-reported data, such as NHIS and NSDUH, for example. A study by Assaf et al., which examined potential gender differences in self-reported smoking data, compared self-reported smoking behavior to serum thiocyanate and serum cotinine levels. The authors concluded that although there were some differences in self-reporting of smoking status by gender, the results were similar between self-reports and the biochemical tests. The authors claimed that the results lent "credibility to the use of self-reports as low-cost accurate approach to obtaining information on smoking behaviors among both men and women in large population-based health surveys" (Assaf 2002). Also, please refer to the validity section of the form I submitted for measure 2020 for more information. In terms of incorporating measure #0027, unfortunately, this measures something different from #2020 so it is not clear how they would be harmonized. I believe that #0027 measures how many smokers (who have had medical visits in the past year) have had conversations about quitting with healthcare providers, which #2020 measures smoking prevalence. Citations: 1. Assaf AR, Parker D, Lapane KL, McKenney JL, Carleton RA. Are there gender differences in self-reported smoking practices? Correlation with thiocyanate and cotinine levels in smokers and nonsmokers from the Pawtucket Heart Health Program. J Women's Health. 2002;11(10):899–906. Another article to reference: 1. Yeager DS, Krosnick JA. The validity of self-reported nicotine product use in the 2001-2008 National Health and Nutrition Examination Survey. Medical care. 2010;48(12):1128–32. Available at: http://www.ncbi.nlm.nih.gov/pubmed/20940652. Accessed August 22, 2012.

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10	Janet Leiker, RN, MPH, American Academy of Family Physicians, Commission on Quality and Practice	Council	2020: Adult Current Smoking Prevalence	Regarding recommended measure # 2020 --Adult Current Smoking Prevalence, which is being revised: Agree with committee members that those serving in the military should be included in the denominator. Also agree that smokeless tobacco should be included.	**Developer response:** Thank you for your comment! In terms of including smokeless tobacco, this would require a separate measure altogether. The smoking prevalence measure has been used for many years and the validity and reliability have been tested in many studies (please see the appropriate section in the report we submitted). Measuring smokeless tobacco prevalence would require a separate measure with separate reliability and validity testing, a separate form etc. We agree that it would be ideal to include the military in the measurement of the smoking prevalence. While the BRFSS, unfortunately does not include the military in their sample, we have no reason to believe that this measure would not accurately measure smoking status in this population or that the validity of self-reported smoking status would differ in this population as compared to the more general population. Many studies examining smoking status in a military population have relied on self-reported data and have used measures similar to the measure used in the BRFSS. For example, a study by Hermes et al., which looked at smokeless tobacco initiation and persistence in relation to deployment, combat, occupation, smoking and mental health symptoms, used self-reported data on smoking status among US service members that was similar to the smoking measure used in the BRFSS. Citation: 1. Hermes ED, Wells TS, Smith B, et al. Smokeless tobacco use related to military deployment, cigarettes and mental health symptoms in a large, prospective cohort study among US service members. Addiction. 2012;107(5):983–94.
11	Submitted by Ms. Carmella Bocchino, MBA, RN	Council	1999: Late HIV diagnosis	Specific rules limiting transmission of information on HIV status currently exist and it is unclear how these limitations will affect this measure.	**Developer response:** " Specific rules limiting transmission of information on HIV status currently exist and it is unclear how these limitations will affect this measure". Surveillance for diagnosis of HIV infection, including diagnosis of stage 3 HIV infection (AIDS), is conducted in all states and states have laws/regulations that mandate this reporting. Because this measure is calculated based on data that have been reported to the surveillance system, there are no limitations related to rules limiting transmission of information on HIV status.
12	Tanya Alteras, National Partnership for Women and Families; Submitted by Mr. Jordan Cooper	Council	1999: Late HIV diagnosis	This measure identifies high risk patients. This measure has the additional benefit of being demographically stratified (by age, race/ethnicity, and transmission category), which allows the measure to be utilized to address well-documented disparities. The measure developers have reduced the time window between a patient seeking care and receiving a diagnosis from 12 to 3 months, prompting greater clinical responsiveness to patients. The measure should also be reported at the facility level, which the developers have acknowledged is feasible.	**Developer response:** " The measure should also be reported at the facility level, which the developers have acknowledged is feasible." This measure can be used at the facility level in closed systems, for example the VA or Kaiser Permanente, that provide the full range of healthcare services. It should be noted that it would not be a useful measure for a facility where people who may not have been in regular care seek care when they become symptomatic. Over time, as integration of care improves under healthcare reform, the measure will become increasingly useful at the healthcare system level (e.g. Accountable Care Organizations).
13	Submitted by Ms. Jennifer Eames Huff, MPH	Council	1999: Late HIV diagnosis	This measure identifies high risk patients. This measure has the additional benefit of being demographically stratified (by age, race/ethnicity, and transmission category), which allows the measure to be utilized to address well-documented disparities. The measure developers have reduced the time window between a patient seeking care and receiving a diagnosis from 12 to 3 months, prompting greater clinical responsiveness to patients. The measure would should also be reported at the facility level, which the developers acknowledged is feasible.	**Developer response:** " The measure should also be reported at the facility level, which the developers have acknowledged is feasible." This measure can be used at the facility level in closed systems, for example the VA or Kaiser Permanente, that provide the full range of healthcare services. It should be noted that it would not be a useful measure for a facility where people who may not have been in regular care seek care when they become symptomatic. Over time, as integration of care improves under healthcare reform, the measure will become increasingly useful at the healthcare system level (e.g. Accountable Care Organizations).
14	Submitted by Dr. Amir Qaseem, MD, PhD, MHA, FACP	Council	1999: Late HIV diagnosis	The American College of Physicians Performance Measurement Committee agrees with NQF Steering Committees recommendation to support this measure for endorsement	**Developer response:** Thank you.

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15	Submitted by Ms. Carmella Bocchino, MBA, RN	Council	0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	While we are supportive of this measure, recent research suggests that Body Mass Index screening alone may not accurately reflect health risk. We do recognize the feasibility of this measure as data can be captured via EHR and thus hard to misrepresent.	**Developer response:** The Centers for Medicare & Medicaid Services (CMS) & Quality Insights of Pennsylvania (Quality Insights) thank you for your recent comment for the 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up measure in the National Quality Forum's (NQF) Population Health: Prevention Project public comment period. While we recognize the additive predictive value of including other paramenters such as waist circimference, as an already complex screening and follow up measure, it would make this measure too complex to try and include both BMI and waist circumference parameters. Also adding complexity is the fact that there is significant variation in waist circumference normals for different ethnic groups. Moving forward, however, we will utilize your thoughts as the possible nidus for additional measure development.
16	Submitted by Ms. Melanie Shahriary, RN, BSN	Council	0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	These comments are being submitted on behalf of the individual ACC members who reviewed this report and do not necessarily reflect the opinion of ACC or its members. I agree with the notion to include calculated BMI and follow-up plan and not BMI per se.	**Developer response:** The Centers for Medicare & Medicaid Services (CMS) & Quality Insights of Pennsylvania (Quality Insights) thank you for your recent comment for the 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up measure in the National Quality Forum's (NQF) Population Health: Prevention Project public comment period.
17	Tanya Alteras, National Partnership for Women and Families; Submitted by Mr. Jordan Cooper	Council	0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	This would be a much stronger measure if it captured the BMI score, rather than just documenting that it was captured.	**Developer response:** The Centers for Medicare & Medicaid Services (CMS) & Quality Insights of Pennsylvania (Quality Insights) thank you for your recent comment for the 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up measure in the National Quality Forum's (NQF) Population Health: Prevention Project public comment period. To provide clarity, the reporting of this measure does require the provider to distinguish between whether the BMI was normal or abnormal. If abnormal, an appropriate follow up plan must be documented based on whether the score was abnormally low or abnormally high. As more providers begin to report this measure from their EMR, the EMR will report the score which will then be used in the calculation algorithm to determine if the appropriate follow up was initiated.
18	Submitted by Ms. Jennifer Eames Huff, MPH	Council	0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	This would be a much stronger measure if it captured the BMI score, rather than just documenting it was captured.	**Developer response:** The Centers for Medicare & Medicaid Services (CMS) & Quality Insights of Pennsylvania (Quality Insights) thank you for your recent comment for the 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up measure in the National Quality Forum's (NQF) Population Health: Prevention Project public comment period. To provide clarity, the reporting of this measure does require the provider to distinguish between whether the BMI was normal or abnormal. If abnormal, an appropriate follow up plan must be documented based on whether the score was abnormally low or abnormally high. As more providers begin to report this measure from their EMR, the EMR will report the score which will then be used in the calculation algorithm to determine if the appropriate follow up was initiated.

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19	Submitted by Dr. Amir Qaseem, MD, PhD, MHA, FACP	Council	0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	The American College of Physicians Performance Measurement Committee (PMC) supports the idea because it is clinically important. However, the PMC suggests that the upper limit BMI cutoff should be >30 for patients of all ages as supported by the recent evidence based clinical guidelines from the USPSTF. http://www.uspreventiveservicestaskforce.org/uspstf/uspsobes.htm	**Developer response:** The Centers for Medicare & Medicaid Services (CMS) & Quality Insights of Pennsylvania (Quality Insights) thank you for your recent comment for the 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up measure in the National Quality Forum's (NQF) Population Health: Prevention Project public comment period. The recent USPSTF clinical guideline states that providers should refer individuals with a BMI > 30 to intensive, multicomponent behavioral interventions. Obesity is defined as a BMI $\geq$ 30. Overweight is defined in the population <65, as a BMI $\geq$ 25 and < 30. In the 6th decade of life weight generally stablizes and most adults will then lose weight with aging. In the population less than 65, however, overweight individuals have a significant risk of becoming obese. Therefore, our Technical Evaluation Panel (TEP) for this measure, felt strongly that providers needed to be more proactive in this population and institute interventions to prevent eventual progression to obesity. The scope of NQF 0421 outlines calculated BMI & follow up interventions for overweight, obese and underweight populations. We hope this information helps to clarify our choice of BMI parameters for this measure.
20	Submitted by Ms. Carmella Bocchino, MBA, RN	Council	0029: Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	This measure is a process metric and we recommend that measure developers revise the measure to include quantifiable data such as physical activity level levels achieved by patient or time spent counseling the patient.	**Developer response:** Thank you for feedback. We will explore options for future measure development.
21	Tany Alteras, National Partnership for Women and Families; Submitted by Mr. Jordan Cooper	Council	0029: Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	This is an improvement from "documentation" measures. It is based on patient responses. It would be even better if the patient were asked if they made changes to their level of physical activity.	**Developer response**: NCQA agrees and will investigate future measures which evaluate patient reported change in level of physical activity.
22	Submitted by Ms. Jennifer Eames Huff, MPH	Council	0029: Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	This is an improvement from "documentation" measures. It is based on patient responses. It would be even better if the patient were asked if they made changes in their physical activity.	**Developer response:** NCQA agrees and will investigate future measures which evaluate patient reported change in level of physical activity.
23	Submitted by Dr. Amir Qaseem, MD, PhD, MHA, FACP	Council	0029: Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	The American College of Physicians Performance Measurement Committee agrees with NQF Steering Committee's recommendation to support this measure for endorsement.	**Developer response:** Thank you for your support.
24	Submitted by Ms. Carmella Bocchino, MBA, RN	Council	0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	This measure is a process metric and we recommend that measure developers revise the measure to include quantifiable data such as physical activity levels achieved by patient or time spent counseling the patient.	**Developer response:** Thank you for feedback. We will explore options for future measure development.
25	Submitted by Ms. Melanie Shahriary, RN, BSN	Council	0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	These comments are being submitted on behalf of the individual ACC members who reviewed this report and do not necessarily reflect the opinion of ACC or its members. The metric for evaluation of compliance with BMI measurement in children 3-17 years looks appropriate.	**Developer response:** Thank you for your feedback.
26	Tanya Alteras, National Partnership for Women and Families; Submitted by Mr. Jordan Cooper	Council	0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	This check-the-box documentation measure does cover an area of importance, however it would be strengthened by also capturing the BMI score.	**Developer response:** While this measure does not capture an actual BMI score, it does require that a BMI percentile be documented. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.
27	Submitted by Ms. Jennifer Eames Huff, MPH	Council	0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	This check-the-box documentation measure does cover an area of importance, however, and would be strengthened by also capturing the BMI score.	**Developer response:** While this measure does not capture an actual BMI score, it does require that a BMI percentile be documented. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

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28	Deb Donovan, Highmark; Submitted by Ms. Leslie Boltey	Council	0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Measure population (3-17 years of age) conflicts with adopted meaningful use measure which depicts denominator as 2-17 years of age. Recommend adjustment to harmonize.	**Developer response:** The intent of this measure is to evaluate whether patients received BMI screening and physical activity/nutrition counseling between the ages of 3 and 17 years. Meaningful use measures calculates age according to the age of the patient at the beginning of the measurement period, whereas the NQF version calculates age as of the end of the measurement period. Therefore we adjusted the age parameters in the MU specifications to capture the same age group of patients across reporting program types.